Concurrent Session Two -- Data Management

David Cotton
Choi Wan
Mari Gasiorowicz

Each of the same speakers delivered the same overview presentations, so they are not repeated here. However, the discussion periods following each presentation have been documented:

Discussion Summary:

Following David Cotton's and Choi Wan's Presentations

- A participant asked whether the system would allow a user to pull specific information such as how many African-American men were served in a given region or in an entire state since this information would be helpful for program planning purposes. Choi Wan replied that one of ERAS's options will be for health departments to be able to access their progress in that manner. He noted that different health departments use different taxonomies, so that feature will not be available on-line, but they will be able to have the information for their agency. ERAS will allow any jurisdiction to access information that they want, bearing in mind the analyses that health departments specify.

- David Cotton pointed out that one of ERAS's limitations is that it is only a way to transfer a jurisdiction's aggregate information to CDC. It cannot look at parts of a jurisdiction, i.e. South Georgia versus North Georgia. The health department software that CDC is talking about developing might allow data stratification, he said. Choi Wan agreed, adding that individual client data would be within the health department's database, not ERAS. Their intention is to give health departments different types of information in the same table for in-depth analysis, incorporating different types of evaluations.

- Given that their department is devoting resources to a web-based system, one participant inquired as to whether they were better off to wait for the CDC system, avoiding training issues involved with switching systems. Another group member was in the same situation, adding that compatibility with ERAS is an issue, as is the possibility that reporting requirements could change, which could prove to be a problem if the health department's system is not conceptualized in a similar manner to ERAS.

- Jaime Altamirano responded saying that health departments that are already developing their own system are thinking not only that they must comply with CDC requirements,

but that they must consider the data needs of their other funders and of their state's and CBO's needs. They are, therefore, developing database systems that are much larger than what CDC may require. If that is the case, then waiting for software that only complies with CDC core requirements may not be satisfactory because of your own state's needs, he said. Waiting until the CDC software comes out to think about those extra needs might not be advisable. States that are working on databases now must remember to collect above and beyond CDC's requirements to ensure that time is not being wasted. Some states have the capacity to develop their own systems, and have done so, while others do not.

- David Cotton said that there are multiple funding agencies for whom health departments manage data. Some states are anticipating all of those needs and integrate them into a single system. "If there were a system that only managed the CDC Guidance data, would that be helpful," he asked the group? The "closed" or "open" nature of that database is a question. An audience member replied that there are other considerations, including resources and other constraints. Experience of staff is an issue, and using globally-developed software means that technical assistance and updates are available. There is an ongoing investment in making sure that the software system runs smoothly and keeps pace with changes in the Guidance or changes in CBO's. Depending on vendors for these issues can be expensive and a negative experience.

- A participant asked whether the CDC program would integrate other systems such as MIS. Choi Wan stated that if a health department has the capacity to do so, then it should create its own system, ensuring that this system can "talk" to ERAS. Each health department has its own factors to consider in making this decision, he said. Upgrades and changes are CDC's responsibility. He told them to wait a few months, unless they were in a hurry, to see how the system takes shape. They should see if the system is something that they can use. The software system is not crucial. It is the data collection mechanism that is crucial, that has buy-in from CBO's and agencies. CDC has the long-term vision that states may be able to link their surveillance, care, and prevention data to allow them to have a comprehensive way to examine implementing programs for their local epidemic. To make this vision a reality, the IT will have to be consistent. CDC is having dialogue with HRSA and other agencies regarding this issue. There are no immediate plans to make system elements the same, but they may be compatible for analysis. The data elements defined by OMB should be the same.

- An inquiry was posed regarding compatibility of New York State and New York City. Choi Wan commented that the systems are not compatible at the moment, but that there are common elements. CDC and HRSA are aware of the discrepancy and are having conversations to find consistencies.

Following Mari Gasiorowicz's Presentation

- A participant asked about entering a narrative progress report. Mari Gasiorowicz replied that they are trying to keep narratives small and focused just on new information that is part of the intervention. For the first year, the state health department enters the intervention plans for the grantees, and then they fill in details.

- Another participant posed a question about budget reports. Mari Gasiorowicz said that they do not reimburse agencies based on expenses. They are paid monthly, and do not have to report actual expenses.

- David Cotton mentioned the ease of the transition from paper data collection forms to the web-based forms. He asked Mari Gasiorowicz to comment on the process that the health department went through to arrive at the paper forms. The forms are still in the pilot phase. They got more input on the intervention plan forms than on the data collection forms. They conducted two days of training on the data collection forms, and then a conference call combined with web-based training prepared agencies for the web-based versions of the forms.

- Jaime Altamirano asked Ms. Gasiorowicz about difficulties that she found in converting from old forms to new ones, and whether it was easy to integrate the new guidelines into the old forms, or if they had to create completely new forms. Mari Gasiorowicz replied that they created new forms, but they retained some elements from previous ones. The new forms are much cleaner. They have found the intervention plans and the intervention population combination to be very successful and clear to people in their state.

- A participant inquired as to whether they submitted their data or their projections of process data to CDC. Mari Gasiorowicz replied that they had not, as they had just completed training and had their prevention plans approved.

- Another participant asked about the state's prevention planning group. Some states have regional planning groups as well, and one of their issues with the guidance tools was wanting to capture how many times they meet on the forms. They felt that those meetings were an important part of what they do. Since they want to capture that information, the state has complied and recorded that infrastructure activity in the "other" category. Mari Gasiorowicz commented that they had funded some CBO's to provide technical assistance to other CBO's or providers, so there is a way to record types of activities such as task forces, events, mini-grants, et cetera. They asked their agencies to classify their activities into one of seven categories, eliminating the "other" category.

- Mari Altamirano spoke about developing forms for data collection and quality assurance. First, he discussed collecting data from outreach workers on their interventions. He talked about whether the forms were filled out immediately on-site, or later via recall. If the whole system works from the field perspective, then they have to think about measuring the quality amount of data collected on the street level. From the street, data then goes to the CBO, which reports to the health department at the regional level, which reports to the health department at the state level, which reports to CDC. At each level, the data reporting should be comparable. The forms must be easy to use at the street level, but must also collect enough information to be aggregated.

- A participant pointed out that technical assistance and security of the website would be two important issues.

Following Jaime Altamirano's Presentation

- Mari Gasiorowicz commented that there are a number of states that have data collection systems that are up and running.

- David Cotton encouraged group members to talk about where they are in their development of data collection and management systems, including their work with their CBO's and agencies, technical capacity, developing new forms, and other issues.

- A representative from North Dakota said they work on a small scale, collecting their data on paper. They have minimal grantees, and they have no CBO's, so their interventions are limited. She can foresee the development of a standardized form that the state can use with each of its contractors. At present, some only submit progress reports, so she hoped that they would create a standardized form and then do the data entry. David Cotton pointed out that because of the nature of the state of North Dakota, resources are centralized, and data entry management at the health department level is a logical direction. She said she will have to develop her own form, keeping in mind how overburdened her grantees are, being local public health organizations. Anything new must be approached carefully. They are already submitting data through a lab, so she can incorporate that system into her forms.

- A representative from Nebraska's said that they are in the middle of their first year of trying to implement the standardized data. They adapted an extant program. They have distributed the requirements for data to their grantees, who will then send the data to the health department for data entry. They do not have high expectations for the first year's data, but they are getting used to the requirement. Their ultimate hope was to have a totally web-based system. In their last round of RFA's, they included a capacity questionnaire. At a minimum, each Project Coordinator must have computer software, hardware, and Internet access, so each grantee does have that technical capacity. To encourage grantees to think about a web-based reporting system, the health department has offered the benefits of those reporting abilities. Their TA will have to include these benefits, including instant report generation. She will also include how they can use the data to apply for additional funds. The department itself will need TA about the data and how its validity can be assured. They have explained the changes by "blaming CDC," which the grantees seem to accept. Jaime Altamirano pointed out that CDC often has to respond to Congressional mandates, especially in the area of definitions. The participant from Nebraska assured the group that they ultimately blame Congress when asked for accountability.

- A representative from New Hampshire said that they are at the paper level, but are hoping to have the new system in place by July 1. They standardized their reporting forms at the end of 1999, and grantees have given useful feedback on the new forms since then. He believed that his state would benefit from being able to show grantees their progress, the ability to interpret data, and how their grant money is being spent. All of their agencies have Internet capability, which will help them go on-line. They seem to be nervous about web-based reporting and do not seem to understand it, but they do not like having to submit forms. Having access to the information for grant-writing purposes as well as for performance assessment is interesting to them. The agencies are currently giving feedback on reporting mechanisms, he added. They will have access to their own raw data.

- Another participant's state introduced the idea of new evaluation items at their state prevention meeting. After that meeting, they assembled their contractors and brain-stormed what data they wanted to collect. They then reconciled those requests with CDC's needs. All of their contractors are reporting on the resultant forms, and they are considering a web-based system. They sub-contracted with a local university to work on it. They have had few problems with the reporting forms, but don't anticipate many problems with converting to a web-based system. Because they got buy-in from field workers into the forms, some directors of agencies are worrying about training, time spent, and dollars involved in the conversion to the web-based system. Their contractors all have access to the technology, and directors are being motivated with the promise of

getting data back. Peers also motivate them to stay engaged in the process.

- A participant from San Francisco showed her draft forms. Their outreach forms include client-level data so that they can track clients that have multiple interactions. Risk behavior information is included. In their single- and multi-session workshops, they collect information beyond Guidance requirements so that they can better describe the epidemic in San Francisco. They are using paper submissions at present, and the new RFP's incorporated documentation needed to fulfill the Guidance requirements. The program managers and the planning unit take burdens off of the agencies by helping with the intervention plan and the monitoring and contract process. Their PCM forms include a quantifying question so that they will know which service a client received, eliminating the need for different forms. They have had difficulty deciding what to put on their Health Communication Information form, so they used the CDC requirements and expect to add more elements later as they learn what will be meaningful to them. They are hoping that the state will give them a copy of their database, which is in development. Issues are related to matching criteria with the state, she added. Regarding culturally-appropriate outreach efforts, they are in the process of translating their CTR forms into Spanish, and that they have other languages as well. In terms of specificity for different populations, they have had to make their standardized forms as minimal and as encompassing as possible. The agencies will have to create forms that take the CDC requirements and add to them.

- A participant from Oregon was excited to be starting from a blank slate. Oregon does not have a history of data collection, so there is no understanding of the taxonomy; there are no standardized forms; and he has the task of designing the system. He was glad to have met people from other states from whom he could learn.

- Another participant said that they had gone to a dual system, creating standard forms for health education and other activities. The process was collaborative, so they have buy-in at the local level. They use a combination of paper and electronic forms. They have centralized data reporting and are building a web-based system. Access to this data in de-centralized systems has been slow, she said, which has been a problem. Their grantees understand that this reporting is part of their contract requirements: memoranda of understanding have been helpful in making grantees understand their expectations and what they can expect from the health department. In the next round of contracts, they will require an Internet service provider and powerful computers. Becoming cohesive has taken time, and more minor modification of some forms will be necessary. They collect aggregate data now, but the cross-tabulation tables are becoming unwieldy. Agencies will be able to access this information via the web eventually which will help.